NOTICE OF INDEPENDENT REVIEW DECISION

February 17, 2003

RE: MDR Tracking #: M2-03-0570-01
IRO Certificate #: IRO 4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in anesthesiology which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 47 year old female sustained a work-related injury on ___ when while working for an airline, she tripped over a passenger and injured her left foot. One treating physician feels that her MRI reveals some abnormalities at the 3rd metatarsophalangeal joint. The patient has been in a walking cast and has used orthotics. The patient still complains of pain in her left foot, however, she has had substantial relief with the use of a galvanic stimulator. The treating physician has recommended that the patient purchase a Smart Wave Galvanic stimulator.

Requested Service(s)

Purchase of a Smart Wave Galvanic Stimulator

Decision

It is determined that the purchase of a Smart Wave Galvanic Stimulator is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has reflex sympathetic dystrophy (RSD) as documented by two physicians. She has not responded well to previous treatment. She had a trial of galvanic stimulation and the medical record documentation describes over 90% relief of pain. The patient also reports better sleep, increased activities, and a better quality of life. Highwave galvanic stimulation is FDA approved for edema reduction and muscle stimulation. Both these modalities are required for this patient with RSD. Therefore, the purchase of a Smart Wave Galvanic Stimulator is medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,

cc: Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 17th day of February 2003.